MARC W TAN

A REVIEW OF THE ALCOHOLISM AND DRUG ADDICTION ACT 1966.

ANALYSIS, PROBLEMS AND SOLUTIONS.

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LAW FACULTY
VICTORIA UNIVERSITY OF WELLINGTON

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ABSTRACT

This paper attempts to review the Alcoholism and Drug Addiction Act 1966. The author submits that the Act has fallen into disuse through the years due to its legislative problems, its failure to keep up with medical progress and its failure to address key areas in society. The paper will first examine the main provisions of the Act, identify its problems and then provide what the author submits to be suitable reforms for the Act to be effective. The paper moves on to the need for compulsory detention orders for the treatment of alcoholics and drug addicts. Finally the paper focuses on three areas which require attention. These are the care and treatment of dual diagnosis patients, alternative sentencing for alcohol and drug offenders and recidivist drink drivers. Throughout the paper, the author will compare the ADAA with the Mental Health (Compulsory Assesment and Treatment) Act 1992 because of the similarities they share. The author submits that the ADAA can be an effective tool in combating the problems of alcoholism and drug addictions in New Zealand by reflecting the treatment options available and increasing the scope of patients covered under the Act.

WORD LENGTH

The text of this paper (excluding contents page, footnotes, bibliography and annexures) comprises approximately 12600 words.

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I INTRODUCTION

> Choose life. Choose a job. Choose a career. Choose a family. Choose a fucking big television. Choose washing machines, cars, compact disc players and electrical tin openers... choose DIY and wondering who the fuck you are on a Sunday morning. Choose sitting on that couch watching mind-numbing, spirit crushing game shows, stuffing junk food into your mouth. Choose rotting away at the end of it all, pishing your last in a miserable home, nothing more than an embarassment to the selfish fucked up brats you spawned to replace yourself. Choose your future. Choose life..But why would I want to do a thing like that?

The quote above comes from Irvine Welsh's hero in *Trainspotting,*[1] Mark Renton. Renton is a drug addict who sees no reason as to why he should satisfy himself with a normal existence as opposed to chasing the highs he gets from his heroin habit. Popular culture in recent years has inundated society with images of drug abuse and alcoholism.

Sadly, alcoholism and drug addiction are problems that plague societies irrespective of their geographical, racial and socio-economic positions. Apart from the harm that is caused to the users themselves, these addictions create major health, social and productivity cost which are borne by society. The government has a paternal responsibility to protect our society from the harms of drugs and alcohol.

It is therefore strange that there has been no cogent national policy on drugs and alcohol until July this year.[2] The Ministry of Health's National Policy on Alcohol and Tobacco[3] is only the first step of a process of implementing resources over a period of six to ten years.[4] It's goal is to minimise harm caused by alcohol and drug use to both individuals and the community.[5]

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[1] I Welsh *Trainspotting* (Minerva, London, 1993).
[2] Ministry of Health *National Drug Policy Part I: Tobacco and Alcohol* (Wellington, 1996).
[3] As above.
[4] As above, 9.
[5] As above, 11.

This paper seeks to examine the current legislative structure which provides some form of social control over the abuse of alcohol and drugs. Under the Alcoholism and Drug Addiction Act[6] (ADAA), alcoholics and drug addicts within its definition may be detained for treatment in one of the certified institutions.

The author submits that the ADAA is ineffective in providing any means of social control because it is antiquated and draconian. This paper will focus on the Act and the problems in the current legislation, after which it will focus on the reforms that are needed for a new Act and the principles that will guide them.

Alcoholism has been neglected for too long by the law and the government. The author submits that this low level of concern is due to the lack of knowledge about the ADAA and the fact that until now there has been no national policy on the harm and use of alcohol and drugs. The author further submits that the Ministry of Health must therefore review the ADAA soon and decide if a legislative response is necessary to solve the problem of alcoholism in New Zealand.[7] This paper will reason why a legislative response is necessary.

A *Structure*

This paper is divided into five major parts. Part II sets out how the current ADAA works.Part III will then focus on the problems existing in the current legislation and provide suitable reforms for those problems. Part IV will elaborate on whether alcoholics and drug addicts may be civilly committed against their will for the treatment of their addictions. It will elaborate on the need to take into account two main principles if we are to provide for compulsory detention orders. These are the protection of patient's right and the 'least restrictive alternative'. The paper then goes on to discuss several areas which the

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[6] Alcoholism and Drug Addiction Act 1966.

[7] The last time the Ministry considered a review was in 1993 but it never got past an issues paper. See L Millar *Review of the Alcoholism and Drug Addiction Act 1966* (Ministry of Health, Wellington, 1993).

author feels has been neglected and which require special attention by the Ministry when reviewing the legislation. Part V deals with dual diagnosis patients. Part VI with alternative sentencing for alcohol and drug offenders and Part VII focues on curbing recidivist drink driving. Finally Part IX concludes the paper.

B Definitions

For the purposes of this paper, the term drug refers to alcohol, prescription drugs of abuse and illicit drugs. It however does not extend to cover tobacco. Drug abuse includes all drugs of abuse such as solvents and aerosols.

II THE ALCOHOLISM AND DRUG ADDICTION ACT 1966[8] (ADAA)

The ADAA is one of New Zealand's lesser known pieces of legislation. It is a remnant of late 19th century English legislation governing chronic inebriates. New Zealand is one of many countries in the world which has legislation enabling civil commitment for the treatment of alcoholics.[9] The responsibility for dealing with drug addicts may either lie with a country's law and enforcement systems or its health system.

A Legislative History

[8] See n 6.

[9] Other countries include Agentina, Australia (Victoria), Bangladesh, Burma, Canada (British Columbia, Nova Scotia), Colombia, Finland, Germany, Hungary, Indonesia, Iraq, Italy, Japan, Malaysia, Mexico, Norway, Pakistan, Peru, Singapore, Somalia, Sweden, Switzerland (Geneva, St Gallen), Thailand, Trinidad and Tobago, Tunisia, Russia, United Kingdom (England and Wales), United States (Federal, Massachusetts, Wisconsin). L Porter, A E Arif & W J Curran *The Law and the Treatment of Drug and Alcohol Dependent Persons* (World Health Organisation, Geneva, 1986).

The predecessor to the ADAA was the Reformatory Institutions Act[10] which made "provision for the establishment and control of reformatory institutions for the reception and the detention of ahbitual inebriates...". This was a penal response to the social problem of alcoholism. It provided the court to make voluntry or compulsory commitals for treatment. Such treatment involved abstinence, a healthy diet and physical work for up to two years.

By the middle of the 20th century, alcoholism was perceived as a disease requiring cure and treatment as opposed to control. Coupled with this change in views was a ministerial directive in 1963 to develope specialist alcoholism treatment units in hospital to provide for medical detoxification, counselling and referral services.[11] Finally in 1966, the ADAA was passed for two reasons. The first was to repeal the Reformatory Institutions Act and the second was to make better provision for the care and treatment of alcoholics and drug addicts. The enactment also shifted the official responsibility for the custodial care and treatment from the Department of Justice to the Department of Health (as they were then known).

The author submits that apart from the shift in responsibility the new Act was substantially similar to the one it replaced. The state still played custodian with the same provisions for inpatient treatment for drug abuse. Furthermore the procedural provisions to apply for a detention order and the offence provisions between the two Acts are also similar. The author submits that the draconian nature of a penal approach to drug abuse problems still remains in the legislation today which is one of many reasons why the ADAA needs to be reviewed.

Since the restructuring of the New Zealand health system into its current form of Regional Health Authority's and Crown Health Enterprises, their main focus has been on the provision of outpatient treatment and rehabilitation programmes for the treatment of

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[10] The Reformatory Institutions Act 1907.

[11] L Stewart & S Casswell "Treating Alcohol Problems in New Zealand : Changes in Policies, Practices and Perspectives" from Alcohol Liqour Advisory Council Library.

alcoholics and drug addicts. This was because the Ministry of Health felt that such services served a greater proportion of society. Thus it has been largely the work of volunteer organisations such as the Salvation Army Bridge programmes which has provided inpatitent treatment facilities.[12] It is important to note that with the shift of drug abuse treatment from an inpatient to an outpatient emphasis, the Act has seen very little use. "In 1983 only 11% of all alcohol-related admissions to psychiatric hospitals and other official treament centres came under the Act." [13] This number has since dropped to less than 10% over recent years.

B Definiton of "Alcoholic' under the Act

The ADAA was set up to treat and rehabilitate alcoholics and drug addicts. These terms are defined in sections 2 and 3. An alcoholic is defined in section 2 as:[14]

> ...a person whose persistent and excessive indulgence in alcoholic liquor is causing or is likely to cause serious injury to his health or is a source of harm, suffering or serious annoyance to others or renders him incapable of properly managing himself or his affairs.

C Defintion of 'Drug Addict' Under the Act

Section 3's definition of a drug addict draws has the same 'dangerousness' requirement but applies to "... any person whose addiction is intoxicating, stimulating , narcotic or sedative drugs." This definition extends to cover glue sniffing since glue contains drugs that are

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[12] In a 1994 survey by the Central Regional Health Authority of service providers for the treatment of alcohol and drug problems, there were 40270 people who attended outpatient treatment facilities and 615 admissions to residential assesment/treatment programmes. Central Regional Health Authority *Alcohol and Drug Services in the Central Regional Health Authority Area* (Wellington, 1994).

[13] As above.

[14] See n 6, s 2.

drugs and are capable of being addictive. In *In Re JPS,*[15] the court accepted evidence from a toxicologist that the drugs in industrial solvents were drugs within the definition of 'drug addicts'. What constitutes an addictive drug therefore are "[a]ny chemical drugs which can so affect the brain cells to cause poisoning, giving pleasurable symptons which a person wants to repeat."[16]

Based on this reasoning, tobacco smoking may be covered under this wide definition for being addictive and containing the drug nicotine. A more restrictive reading of the section would be to only allow addictive drugs that were mind altering.

D Certified Institutions Under the Act

The ADAA is only as effective as the resources that support it. The Act only concerns inpatient treatment and committed patients may only be detained for treatment in the institutions certified under the Act. In fact, it is essential in the making of any detention order that there be evidence that the manager or the superintendent of such an institution is wiiling to receive the patient for such treatment. According to the last round of certification by the Ministry of Health done in 1992, there were 15 such certified institutions in New Zealand. These included both public and volunteer hospitals and institutions. The public hospitals are Kingseat, Oakley, Porirua, Carrington, Cherry Farm, Sunnynook, and Tokanui hospitals. The other volunteer programmes include the Salvation Army bridge programmes in the three metropolitan areas and the Totara Trust in Materton.

However, the Ministry has failed to keep an accurate and up-to-date record of these institutions since several of these instituitons are now longer in existence and there are other private instituions in New Zealand which have not been certified under the Act. Institutions such as Odyssey House have been preferred by the courts in alternative sentencing measures for alcohol and drug offenders because of their structured and supervised

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[15] *In re JPS* (1984) 2DCR 327.

treatment programmes.[17] It is important that for the Act to work effectively, a comprehensive and up-to-date list of the certified institutions be kept and circulated to the judiciary, health practitioners and members of the public.

E Detention Orders under the ADAA

The substantive provisions of the ADAA concerning the application of detention orders are covered in sections 8 to 11. Compulsory detention orders made under the Act may be for no more than 2 years duration.[18] There are two ways in which a detention order may be sought. Section 8 allows for a person to 'voluntarily' apply for a detetention order. The applicant must state the specific institution to be received into and undertakes to remain in the institution until they are released or discharged under the Act.[19] If the judge is satisfied that the applicant comes within the definition of the Act[20] and that they fully understands the nature and effect of the application, the judge may make an order for detention as long as a manger or superintendent of the institution is willing to receive the applicant.[21]

Section 9 enables relatives, the police or other reputable persons to make an application for any person believed to be an alcoholic. Because the order is being made by someone other than the patient, section 9 imposes stricter criteria before such an order may be made. All statements in the application must be verified by a statutory declaration[22]. Furthermore two medical certificates must be submitted with the application. These must state that they believe the person to be an alcoholic under the ADAA. If the judge is then satisfied as to the

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[16] As above, 329.
[17] See below part VI.
[18] See n 6, s 10.
[19] See n 6, s 8(2). See appendix attached.
[20] This is within the definition of the ADAA which includes drug addicts as well. See n 6, s 3.
[21] See n 6, s 8.
[22] See n 6, s 9(3).

truth of the application, an order may be made so long as a manager or a superintendent of a certified institution[23] is willing to receive the person.

Section 9 gives the judge the power to make a warrant for the arrest of the alleged alcoholic if he or she refuses to undergo examination by 2 medical practitioners[24] or if necessary to compel the alcoholic's attendance.

F Sections on Reception, Transfer and Discharge

Sections 12 to 22 refer to the reception, transfer and the discharge of committed patients under the Act. Section 12 states that when an order for committal is made under section 48A of the CJA,[25] the patient shall be transferred to a certified institution upon the expiry or early release of the patient from imprisonment. A committed patient may be discharged, transferred to another consenting institution or released for a leave of absence[26] by the following bodies;[27]

1) the Minister of Health,[28] or;

2)the supervising committee (if any) of the institution,[29] or;

3) the superintendent of the institution.

A leave of absence may be granted by the hospital superintendent but section 20 only allows the leave of absence to be revoked by the judicial process. This causes a problem when patients go on leave to areas where there are no permanent magistrates and relapses into bouts of drunkeness or drug abuse. The detaining hospital can not recall the patient since it would be unlikely that a magistrate would make a special trip to revoke the order

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[23] These are decided by the Ministry of Health and a list of the certified institutions are published in the Gazette. However the last time the Ministry compiled such a list was 1992. Sucessful rehabilitation centres such as Odyssey House in Auckland have also not been listed.

[24] See n 6, s 9(5).

[25] This section is strangely ommitted in the new Criminal Justice Act 1985. See below part VI.

[26] The leave of absence may not exceed the balance of the period of 2 years which the patient is liable to be detained.

[27] See n 6, s 17.

[28] See n 6, s 2.

and the patient herself would probably be too ill to be taken to court. It seems strange that a superintendent who would have the most knowledge of a patient's condition may allow for a leave of absence but is unable to revoke it.

Under section 18,[30] committed patients may only apply for a discharge 6 months after their first reception into the institution. The application is first made to the Minister, the supervising committee or the superintendent. If that request is refused, then the patient may appeal to the High Court to make a discharge order.[31]. The judge may order that the applicant be brought before him and evidence be presented to decide if the applicant shall continue to be detained. Section 18(4) allows the judge to take into consideration that a friend or relative is able and willing to take care of her. A question remains as to why this specific provision for such help by a relative or friend to be taken into account only applies upon an appeal to the High Court. The author submits that such evidence would also be relevant to a judge making a section 9 order and that if section 18(4) remains, then an equivalent provision be provided for under section 9. This would also be consistent with the 'least restrictive alternative' principle. In the situation that resources are inadequate to provide inpatient treatment, less serious cases of alcoholism and drug addiction should be cared for at homeonly if a friend or relative is willing and able to provide an adequate standard of care.

G The Offence Provisions

The ADAA provides for certain offences in sections 24 to 29. The author submits that the antiquated and draconian aspects of the Act are best reflected in the offences provisions. Section 25 states that it is an offence to escape or attempt to escape from an institution or lawful custody. This includes reusing or failing to return to the institution after a leave of

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[29] See n 6, s 7.
[30] See n 6, s 18.
[31] See n 6, s 18(1).

absence. Section 26, in a similar vein, states that a patient who is wilfully guilty of any violent, unruly, insubordinate, destructive, indecent, offensive or insulting conduct is also guilty under the Act. All offences may be punished with a term of imprisonment not exceeding 3 months and/or a fine not exceeding $200.[32]

The offence provisions serve no purpose in the treatment and rehabilitation of alcoholics, rather they seem to be psychological threats made to the committed patients to behave and adhere to their treatment programmes. In his many years working with alcoholics, Major Don Hutson has not heard of any persons being convicted under the offence provisions.[33] It seems strange that persons suffering from behaviourial disorders such as drug abuse may be liable for such offences.[34] Although drunkeness does not absolve a person of liability in criminal law, the offence provisions seem inconsistent with the purposes of the Act and serve no real purpose. The author submits that the offence provisions are a further remnant of the old penal attitude to drug abuse. In order to be consistent with the humanitarian approach of the Ministry towards drug abuse, the author submits that the offence provision should be removed.

H Procedure Under the Act

Section 35 states the legal procedure to be used in determining a treatment order. All applications shall be heard and determined in private[35] and such persons may be heard and to give and call evidence.[36] In the case of *In re Mrs M,*[37] an application was accompanied by two medical certificates as required by the ADAA. The court held that for such an application under the Act, a hearing was required. Judge Bremmer stated in the case;[38]

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[32] See n 6, s 35.
[33] Interview with Major Don Hutson, Associate Secretary, Salvation Army Territorial Headquarters.
[34] See below part VI.
[35] See n 6, s 35(1).
[36] See n6, s35(2).
[37] *In re Mrs M* [1993] DCR 673.
[38] As above, 674.

> that if Mrs M so wishes, the doctors can be examined and cross-examined, the applicant can be examined and cross-examined, and any other evidence which Mrs M considers relevant may be adduced.

He further went on to state that such a hearing would only be a substantive hearing and not a pro forma one as is akin to hearings under the Mental Health (Compulsory Assssesment and Treatment) Act (MH(CAT)).[39] His honour also said that:[40]

> there can be no doubt that Mrs M was either arrested or detained under section 23 of the New Zealand Bill of rights Act 1990. She has the right to consult and instruct a lawyer without delay and to be informed of that right.

Therefore all alleged alcoholics are entitled to legal representation at a hearing for a detention order.

III PROBLEMS UNDER THE CURRENT LEGISLATION

There are many problems in the current legislation. This is because the ADAA is predominantly a reflection of the penal attitude towards drug abuse. Furthermore, the Act has failed to keep up with the medical advances towards drug abuse. The defintions of an 'alcoholic' and a 'drug addict' are the starting points of these problems.

A The Definition of an 'Alcoholic' in Section 2

The current definition of an alcoholic in section 2 is antiquated and ambiguous in its requirements. It is a legal defintion as it is the judge who decides who is an alcoholic although he/she would do so with aid from the two medical certificates provided as evidence.[41] It is interesting to note that in comparing the definitions between an alcoholic and a drug addict in sections 2 and 3 respectively, there is no reference in section 2 to an

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[39] Mental Health (Compulsory Assesment and Treatment) Act 1992.
[40] See n 37, 674.

'addiction'.[42] Rather it refers only to a "persistent and excessive indulgence". Therefore it is possible for a stubborn binge drinker to be covered under the act even though he/she may not be an alcoholic in medical terms. However Brookbanks states that:[43]

> the requirement 'and excessive indulgence' suggests a state of habitual disability caused by alcoholic consumption as opposed to an incident of alcoholic overindulgence after which a person is free to pursue normal activities unconstrained by the effects of alcohol.

This interpretation is consistent with the objectives of the Act. However the author submits that the current definition is antiquated and is a remnant of the penal view of alcoholism, which was to rid the streets of inebriates. This is opposed to the more medical definition used in section 3 which refers to an 'addiction'. To be consistent with the view of alcoholism as a medical disorder and the definition of 'drug addict' in section 3, section 2 should be amended to refer to a person with an addiction to alcoholic liqour.

1 The 'Dangerousness' requirement

The section also states that a person is an alcoholic or drug addict if he is;

i) causing or likely to cause serious injury to his health, or;

ii) is a source of harm, suffering or serious annoyance to others, or;

iii) renders him incapable of properly managing himself or his affairs.

It is important that since the Act concerns civil commitment, only alcoholics or drug addicts that are likely to be a danger to themselves or society may be committed. The author submits that the current 'dangerousness' requirement is vague and open to a number of interpretations. The term 'serious annoyance' especially would seem to encompass a large number of people at bars past midnight. The author submits that for the ease of statutory

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[41] See n 6, s 9.
[42] See above part II B and C.
[43] *Trapski's Family Law* (Brookers, Wellington, 1995), vol III, Alcoholism and Drug Addiction, ch Ca, 5.

interpretation, the dangerousness requirement be amended to that used in defining 'mental disorder' in section 2 of the Mental Health (Compulsory Assesment and Treatment) Act.[44]

Thus section 2 would read:

Alcoholic' means a person whose addiction to alcoholic liqour poses a serious danger to the health or safety of the person or of others, or seriously diminishes the capacity of the person to take care of himself or herself.

B 'Voluntary' Applications

The procedures for detention orders are also flawed. Section 8 concerns 'voluntary' applications for treatment and detention, however the question remains as to what degree are these applications 'voluntary'? The author submits that in truth a large number of these application will be made with some sort of coercion from family members, employers or other members of society. It is likely that if there was a voluntary attempt to treat a problem, the alcoholic would probably opt for other forms of treatment which would allow him or her to remain in society. Therefore, in truth, section 8 is an easier way to commit somebody under the Act since it does not require 2 medical certificates in the application. The author submits that by allowing for a voluntary application under the Act, it is seen as the first step by a alcoholic towards recovery. Although the person may be coerced into making such an application, by doing so themselves, the abuser has at least recognised that they have a problem which must be treated.

It is strange that the requirement of two medical certificates is omitted under section 8 since the dubious nature of a 'voluntary' application may mean that a person who is not a certified alcoholic or drug addict may still be committed under the Act. The author therefore

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[44] See n 39, s 2. The 'dangerousness requirement' in the definition of 'mental disorder' is " ... (a) poses a serious danger to the health or safety of that person or of others; or (b) seriously diminishes the capacity of that person to take care of himself or herself;- ...".

recommends that in any review of the ADAA, the requirement of two medical certificates should be inserted so as to safeguard the alleged alcoholic or drug addict.

Although a person may voluntarily commit themselves for treatment under the ADAA, they may not revoke their consent and then seek to leave the institution. Section 8(2) states that "... the applicant undertakes to remain in the institution, for treatment for alcoholism, until he is released or discharged under this Act."[45] It is possible that such a restriction of the patient's rights would be a breach of section 11 of the New Zealand Bill of Rights Act.[46] Section 11 states that "[e]veryone has the right to refuse to undergo any medical treatment." Therefore if a person has consented to be treated for their addiction under section 8, should they not have the right to refuse their treatment at any time and leave the institution? In *In re S*[47], a patient from a psychiatric institution would not accept one of the conditions of his release which was to be submitted to regular medication at his home. Barker J stated that 'everyone' in respect of section 11 meant "every person who is competent to consent."[48] Therefore if a person consents to being detained by applying for such an order under section 8, he or she should be allowed to revoke their initial consent and choose to leave the insitution.

It is also possible to argue that when a patient agrees to "remain in an institution for treatment"[49], should the institution fail to provide such treatment, the patient's detention may be an arbitary detention of the patient against his or her will. This would be in breach of section 22 of the NZBORA.[50] and may even constitue "unlawful detention" under section 24 of the ADAA. Therefore if a patient is not being treated effectively by the institution or refuses to be subject to such treatment, the person should be discharged.

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[45] See n 6, s 8(2).
[46] New Zealand Bill of Rights Act 1990.
[47] *In re S* [1992] 1NZLR 363.
[48] As above, 374.
[49] See n 6, s 8(2).
[50] See n 47.

The author submits that in order for section 8 of the ADAA to be read consistently with section 11 and section 22 of the NZBORA,[51] a voluntary detainee should be able to leave the institution at any time. If the institution or any parties who may have 'coerced' the applicant into a volunteer application feel that the applicant's departure is premature and that he is still in need of further treatment, then they may apply to compulsorily detain him under section 9. The blanket exclusion thus seems to be an infringement of the right to refuse medical treament and may even constitue an 'arbitary detention' of the patient.

C Problems with Section 9 of the ADAA - Burden and Standard of Proof

The main problem with section 9 of the ADAA concerns the standard of proof which the application must satisfy. Currently, section 9(7) of the ADAA requires that "the [District Court Judge] may if he thinks fit, and is satisfied of the truth of the application, ... make an order requiring the alcoholic to be detained for treatment for alcoholism in that institution."

However the question is what will 'satisfy the judge of the truth' of the application? There has been no case law elaborating on this point with regard to the ADAA. The term 'is satisfied' is used in determining several issues under the MH(CAT).

As opposed to the adverserial approach of the New Zealand legal system, there is no set standard of proof which applies to the ADAA or the MH(CAT). Rather, because it is a piece of social legislation, the proceedings involves an inquisatorial approach. Justice Grieg in *Re M*[52] stated:[53]

> Once the inquiry has been embarked upon I think that there is no particular onus either way but that the Judge upon the whole of the evidence must satisfy himself as to the state of mind and the self or public interest inrespect of the patient. Clearly the standard required for satisfaction must be on the balance of

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[51] As above.
[52] *Re M* Unreported, 21 April 1986, Wellington High Court Registry, M716/85.
[53] As above, ??

> probabilities but since there is the question of detention ... special regard will be given to that restriction of liberty of the person and the general desirability that all persons should be free.

Therefore the standard of proof is the balance of probabilities with special regard to the restricton of liberty. Such an inquisatorial approach may be similar to that used in Mental Health proceedings where the judge will meet the alleged patient and take into account all matters at the hearing, even hearsay evidence. To have an adverserial approach would run against the humanitarian nature of the ADAA and the MH(CAT) since the doctor or aggrieved relative seeking to commit the patient would be seen as the patient's adversary when they are trying to treat the patient.

This standard of proof indicates where the burden of such proof lies in the making of a commital order. Since the hearing is inquisatorial, the parties involved must present their evidence before the judge and allow the court to 'be satisfied'. Thus there is no specific onus on any of the parties in the commital process. However there is a presumption against commital and the author submits that in a commital hearing, it is most likely that the party making the application will have to provide the evidence as to why the patient should be committed.[54]

> But as it is the [Responsible Clinician] who has made the application, for an order having a significant impact of personal freedom, the RC should bear the burden of bringing forward evidence to shoe the criteria are met.

D The Term of a Patient's Detention

If a person is detained under the ADAA for treatment, he or she may not be detained for more than 2 years after his or her first reception into an institution pursuant to the order.[55] This period is decided by the judge after he or she has been presented with the evidence. A

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[54] J Dawson, J Anderson, S Mcarthy "The Mental Health (Compulsory Assesment and Treatment) Act 1992" (New Zealand Law Society Seminar, Wellington, 1993), 15.

committed patient is then sent to a certified institution for a minimum period of six months before they may apply for a discharge from the institution.[56]

The problem here is that the judge must decide on the patient's length of committal. Often the judge's only medical evidence would be two medical certificates testifying simply if the alleged person was an alcoholic. These certificates would not have any information on what the desired length of detention would be. The author submits that at this point, the judge making the order has insufficient knowledge and information concerning the alcoholic to decide upon the length of that person's detention.

The author submits that the ADAA should adopt an assesment procedure similar to that provided for in the MH(CAT).[57] Such a procedure would involve a detailed assesment process to decide if the patient was truly an alcoholic and if compulsory treatment was truly desirable. Only after these levels of medical certification and assesment,would there be sufficient information to decide if an application should be made before the court for a compulsory detention order. This would aid the judge since it would provide a greater amount of medical input in deciding the viability of a compulsory detention order and its duration.

E Conclusion

If the ADAA is to be reviewed, these concerns must be solved. The definitions and the procedures involved in making the detention orders are crucial to the efficacy of the Act. The definitions must be comprehensive enough to promote use of the act and the procedures must be simple enough for anybody to make an application.

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[55] See n 1, s 10.
[56] As above, s 18.
[57] These procedures are set out in Part I and II of the MH(CAT). Upon an application for assesment, the patient is examined and then a certificate of preliminary assesment decides if the patient is mentally disordered. If he or she is, they are then detained for 5 days to decide if further assesment and treatment is desirable. If so, they are detained for a further 14 days to decide finally if the patient is fit to be released from

IV CIVIL COMMITMENT VS PERSONAL LIBERTIES

As a developed and democratic nation, there is a delicate line to draw between a person's indivdual liberties and the treatment and rehabilatation of that person. Is a state allowed to detain a person against his or her will for the treatment of their alcohol and drug addiction? A similar question was raised when the Mental Health Bill was introduced. In assesing the use and efficacy of the ADAA, the MH(CAT) is a useful comparison for various reasons. They both deal with compulsory treatment orders for behaviourial disorders and both provide treatment and rehabilitation for such disordered people.

Traditionally,[58] behaviourial disorders have been dealt with by the penal system. Such disordered people would have been locked away with no real emphasis on their treatment or rehabilitaion. Such behaviourial disorders include mental illness, sexual psychopathy, drug addicts and alcoholics. What these disorders do is to infringe socially accepted norms of behaviour. Society has dealt with such socially unacceptable behaviour through punishment. However, such punitive measures have little effect on those who are behaviourially disordered. Incaceration will not stop them from reoffending or being a threat to society as it does not remove thier disorders which are often the causes for their offending.

In 1992, by passing the MH(CAT) parliament decided that in certain circumstances, it was justifiable to override a patient's civil liberties and impose compulsory treatment on the patient. The ADAA currently provides an existing legislative structure for the civil commitment of alcoholics and drug addicts. However if the Ministry of Health were to attempt a review of the ADAA, it would have to justify why civil commitment is necessary in this day and age when such treatment has shifted to an outpatient focus.

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compulsory status. If they are not, then an application may be made to the court for a compulsory treatment order.

[58] This is evidenced in the Reformatory Institutions Act 1907.

> "The only justification for depriving a person who has not committed a criminal offense of his liberty is that the risk of leaving him at large is substantial, and that everything will be done to make him well again so that his liberty may again be restored to him."[59].

It is widely acknowledged that there is a strong correlation between social disorder and alcoholism. In fact it would be naive to reason that a person who wants to drink himself to death at home is only causing harm to himself. There is harm being caused to his family and society at large by his disorder.

> "Alcohol affects those around the user, causing community and family dislocation; and is the highest contributor to mortality and morbidity among young people."[60]

Problems such as traffic accidents, falls, drownings, street violence, family violence and unsafe sex practices are all reason why alcoholism and drug use should be controlled. This social self-interest is attained through civil commitment by safeguarding the community from harm and at the same time treating these harmful persons.

Furthermore, the state has a paternalistic responsibility towards its citizens. Where such people are incompent to look after themselves, the state has a responsibility to look after such people. This is consistent with the common law doctrine of *parens patriae* where the court assumes the role of a gaurdian over someone who is incapable of looking after themselves. Such is the case of the manic depressive who repeatedly attempts suicide. For their welfare the state must step in to care for such people. This is consistent with the humanitarian approach of treatment and rehabilitation emphasised by the MH(CAT) and the ADAA.

A consistent trait of alcoholism is the failure by the person to acknowledge that they have a problem. Thus there is a school of thought that in some cases, civil commitment is necessary to coerce the person into treatment for their problems. There is another school of thought that opines that such treatment is unsucessful unless the patient voluntarily accepts

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[59] M P Grad, A L Goldberg & B A Shapiro *Alcoholism and the Law* (Ocean Publications, New York, 1971), 66.

such treatment. In reality, there is little difference in the outcome of the two treatment methods. Major Don Hutson of the Salavation Army says that there is an equal amount of sucess between voluntary patients and patients who have been committed under the Act.[61] In a situation where there will always be people unwilling to accept treatment, the author submits that the ADAA is essential to provide extensive coverage and treatment for alcoholics and drug addicts. The state can not ignore alcoholics simply because they will not accept treatment. Such alcoholics, must for both society's and their own good, be compelled to receive treatment.

However if there is to be such legislation which allows the state to infringe on a person's individual liberty and freedom when necessary, such powers must be excercised within certain guidelines. Two principles which must be taken into account are the 'least restrictive alternative' and the adequate protection of the patient's rights.

A *'Least Restrictive Alternative'*

The 'least restricitve alternative' is an important guideline in the excercise of any activity which may trade off civil liberties for society's interest. It states that a person's basic rights may only be restricted to the extent that is necessary to carry out a valid purpose. This principle is stated in section 8(a) of the PPPRA. "To make the least restrictive intervention possible in the life of the person in respect of whom the application is made having regard to the degree of that person's incapacity:"[62]

Under the PPPRA, the court has jurisdiction (in respect of personal rights) in respect of any person who:[63]

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[60] Ministry of Health *Issues paper towards a National Drug and Alcohol Policy.* (Wellington, 1995).
[61] See n 33.
[62] The Protection of Personal and Property Rights Act 1988.
[63] As above, s 6.

> (a) Lacks or wholly or partly, the capacity to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare; or
>
> (b) Has the capacity to understand the nature, and to foresee the consequences and decisions in respect of matters relating to his or her welfare, but wholly lacks the capacity to communicate decisions in respect of such matters.

There must either be an inability to understand or an inability to communicate. The inability to understand is similar to the diminished capacity for self care requirement in section 2 of the ADAA. Therefore an alcoholic or a drug addict who is likely to "cause serious injury to his health" may be lacking to ability to understand the consequences of his decision not to receive treatment for their addicitons.

A "right to independence" in the Code of Rights prepared by the Health and Disability Commissioner's office gives each consumer the "right to service designed to optimise independence..."[64] Therefore such service providers must ensure that patients are given the right to maintain a normal independent life as far as possible. Such a fine balance between society's interest and an individual's personal freedoms could be achieved through community treatment orders for alcoholics and drug addicts in any new ADAA.

B Community Treatment Orders

Community treatment orders are currently available under the MH(CAT).[65] They require the patient to receive treatment from an employee of a specified institution at the patient's place of residence or some other specified place.[66] In consistency with the principle of the

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[64] Health and Disability Commissioner *Code of Rights for Consumers of Health and Disability Services* (Wellington, 1996), cl 2.
[65] See n 39, s 29.
[66] See n 39, s 29(1).

'least restrictive alternative', community treatment orders are the preferred form of treatment under the MH(CAT).[67]

Therefore the author submits that as part of any review of the ADAA, the Ministry of Health should consider the use of community treatment orders in their treatment of alcoholics and drug addicts. The working group on Alcohol and Drugs set up by the Prime Minister's Department recommended the following legislative measures:[68]

> That the Alcoholism and Drug Addiction Act can be reviewed to enable a wider range of cases to be compulsorily assesed and to include provision for flexibility of treatment in the community or in a residential centre.

This is feasible for various reasons.

The majority of treatment measures already available are outpatient rehabilitation and treament measures. This would be a policy issue by the Ministry to direct Regional Health Authorities to channel more resources into such services. Such orders would also be consistent with the 'least restrictive alternative' principle in the PPPRA and in the common law.[69] Furthermore, the current legislation only prescribes for compulsory treatment orders which are extreme and unpopular. Compulsory treatment orders only apply to a small percentage of alcohlics and drug addicts obtaining treatment. They are also unpopular since outpatient treatment procedures such as rehabilitation and methadone programmes allow the patient to remain in society. In order to be consistent with medical trends favouring outpatient treatment, such measures should be favoured. By providing a more common treatment measure, this will ensure greater usage of an under-utilised Act and would also reflect judicial attitudes in alternative sentencing.[70] The author submits that a current flaw

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[67] See n 39, s 28(2).
[68] Report of Working Group on Alcohol and Drugs *To develop a co-ordianated national stategic approach for the management of programmes that address the misuse and abuse of both alcohol and drugs.'* (Department of Prime Minister and Cabinet, Wellington, 1993), 22.
[69] *Mitchell* v *Allen* [1969] NZLR 110.
[70] See below part VI.

with the ADAA is that it is not an accurate reflection of the variety of treatment measures available and the use of community treatment orders would rectify this situation.

C Patient's Rights

There are no provisions in the current ADAA which serve to protect patient's rights once they have been committed under the Act. In a proposed review of the ADAA in 1993, one of the key areas which needed improvement was to improve protection of a patient's rights.[71] Section 23(5) of the NZBORA[72] states that a person, upon detention under the Act, shall "... be treated with humanity and with respect for the inherent dignity of the person."

The other current legislative provision for the protection of a patient's rights is contained under the Health and Disability Commissioner Act (HDC).[73] The Health and Disability Commissioner's office has since drawn up a code of rights for consumers of health and disability services. The Code ensures that consumers are provided with a minimum level of rights in obtaining health and disability services. Besides the right to independence as mentioned before,[74] it also provides the consumer the right to make an informed choice and give informed consent[75], the right to have support persons[76] and most importantly the right to complain.[77] The author submits, at present, where no specific rights are guranteed under the ADAA, it is possible for a committed patient to come under the scope of the HDC since they would be consumers of such health services under the HDC.[78]

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[71] L Millar*Review of the Alcoholism and Drug Addiction Act 1966* (Ministry of Health, Wellington, 1993).
[72] New Zealand Bill of Rights Act 1990.
[73] Health and Disability Commissioner Act 1995.
[74] See above part II A.
[75] See n 64, right 7.
[76] See n 64, right 8.
[77] See n 64, right 10.
[78] See n 73, s 2.

Similar rights are echoed in part VI of the MH(CAT). The Act provides specific rights such as the right for respect for cultural identity,[79] the right to legal advice,[80] the right to company and seclusion, the right to treatment,[81] the right to receive visitors and make telephone calls,[82] the right to receive and send letters and postal articles[83] and most importantly the right to make a complaint of a breach of any of those rights.

The author submits that the MH(CAT) and the Code of Rights indicate that there is a need to protect patient's rights, even more so when a patient has been compulsorily detained at the loss of his individual freedom. Salient rights such as the right for support and to receive letters are essential to allow the patient support from the family and their loved ones. Such outside factors often aid in reintegrating the patient into society and even help the patient become more receptive to treatment. Therefore in a review of the ADAA, specific provisions must be enacted to protect the patient's rights.

D Complaints Process

One of the salient rights which should be granted to all patients under the ADAA is the right to make a complaint for a breach of the patient's rights. This ties into the the review process currently available under the ADAA. This review process operates in a limited sense since it only allows for a patient to apply for a discharge from detention six months after their first reception into the institution.[84] The Act also provides for an appeal to the

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[79] See n 39, s 65.This is in relation to section 5 of the Act, which states that "every court, tribunal, or person that or who exercises any power, under this Act in respect of any patient shall do so- (a) with proper respect for the patient's cultural and ehtnic identity, language, and religious or ethical beliefs; and (b) with proper recognition of the importance and significance to the patient of the patient's ties with his or her family, whanau, hapu, iwi, and family group, and the contribution those ties make to the patient's well-being."

[80] See n 39, s 70.

[81] See n 39, s 66.

[82] See n 39, s 72.

[83] See n 39, s 73 & 74.

[84] See n 6, s 18.

High Court if the initial application is refused.[85] The author submits that the current process is insufficient as it does not address complaints about the treatment process or the patient's conditions. All it is concerned with is whether the patient is fit for discharge.This sole remedy may even conflict with the 'right to treatment'. Whilst it is possible to utilise the Health and Disability Commissioner in making a complaint, this would be time consuming and inefficient compared to a complaints structure built into the ADAA. This is because advocates would have no specialist knowledge in dealing with the processes and the Complaints Review Tribunal is a forum shared by other public bodies such as the Ombudsman's Office, the Privacy Commission and the Human Rights Commission. A more specialist and informal process similar to that in the MH(CAT) would be more suitable.

The MH(CAT) has no set body to investigate complaints by patients, rather a patient may make a complaint which will then be referred to a district inspector or an official visitor.[86] If the matter is not settled, it may go on to the Director of Area Mental Health Services and even the Review Tribunal.[87] This informal complaints process would be sufficient in an ADAA structure to safeguard patient's rights.

V DUAL DIAGNOSIS

In recent times, the area of drug abuse which has required the most attention has been those of "dual diagnosis" or "co-morbidity" patients. "Dual diagnosis" patients suffer from both alcohol/drug addictions and some form of mental disorder as well. The authorities have recently recognized the lack of proper referral and treatment facilities for "dual

[85] See n 6, s 18.
[86] See n 39, s 75(1).
[87] See n 39, s 75(2) & (3).

diagnosis" patients.[88] The Ministry of Health in releasing its national policy on tobacco and alcohol stated:[89]

> Health outcomes for this group are much poorer than those for people with either disorder alone. There is some evidence that this group may not be adequately treated by either specialist mental health or specialist drug treatment services.

As a result of the complexity and severity these patients present to the health system, the patients form a "difficult-to-treat, poorly compliant, recidivist group."[90]

Whilst there are no specific numbers kept on the number of "dual diagnosis" patients in New Zealand, experts believe that they form a significant proportion of patients treated for either mental health or drug abuse services.[91] Furthermore it is expected that this proportion will grow as doctors become more aware of the problems and become more skilled at identifying dual diagnosis patients.[92]

This lack of proper treatment or care may be attributed to both legislative loopholes and inefficiencies within the health industry. This part seeks to evaluate the main faults inherent in the legislative and health structure and endeavours to provide reforms to correct this growing problem.

A Legislative Loopholes??

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[88] This was recognized in the Mason report. See Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley *Inquiry Under Section 47 of the Health and disability Services Act 1993 in Respect of Certain Mental Health Services* (Ministry of Health, 1996).

[89] See n 2, 28.

[90] Ministry of Health *Guidelines for the Management of Patients with Co-existing Psychiatric and Drug Use Disorders* (Wellington, 1994), 4.

[91] It is estimated that between 35% to 85% of psychiatric patients also have alcohol or drug problems. See n 88.

[92] See n 90.

The ADAA and the MH(CAT) are the main pieces of legislation concerning "dual diagnosis" patients in New Zealand. In drafting the MH(CAT) legislation, it was envisaged that the two acts would provide adequate coverage for "dual diagnosis" patients.

Section 4(d) of the the MH(CAT) states that "A person shall not be considered mentally disordered simply by reason of their...drug abuse."[93] It is important to note that section 4 is not seen as defining 'mental disorder'[94] but is an exclusion provision of the MH(CAT). This restriction on the narrow definition of "mental disorder" covered by the section has left some scope for interpretation.

The definition may be read in two ways. First, that the MH(CAT) may not make compulsory treatment orders for persons suffering from drug abuse **even** if they are mentally disordered under the Act.[95] Therefore the MH(CAT) would not include people who were both mentally disordered and a drug addict at the same time. This interpretation would not ignore "dual diagnosis" patients entirely since it is envisaged that they would be covered under sections 2 or 3 of the ADAA.

The second and wider interpretation is that Mental Health Compulsory treatment orders may be made for patients who are both mentally disordered and alcoholics. The section 4 restriction would restrict applicants only suffering from drug abuse and not mentally disordered. Both interpretations would still be consistent with the ADAA legislation which would only apply to drug abusers. The author submits that, however due to the inefficiencies of the ADAA legislation and lack of adequate service providers, if a 'dual diagnosis' patient is not covered by the Mental Health Act, it is possible that the patient may not beprovided for under both Acts.

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[93] See n 39, s 4(d).
[94] See n 39, s 2.
[95] See n 39, s 2. This requires the application of the two limb test for being mentally disordered as defined by the Act. The person must be of an abnormal stste of mind, whether of a continous or an intermittent nature, which is characterized by delusions or by disorders of mood, volition, cognition or perception; AND it must be of such a degree that it: poses a serious danger to the health or saffety of the person or of others; OR seriously diminishes the capacity of the person to take care of himself or herself. (Emphasis added.)

Recent case law has sought to clarify section 4's proper interpretation. The latter and wider interpretation was supported by the Mental Health Tribunal in *In the Matter of B*[96]. The case involved B who as a result of alcohol abuse through the years had suffered brain damge. He was therefore a 'dual diagnosis' patient being mentally disordered as well as alcohol dependent. Both the clinician and independent psychiatrist agreed that B posed a serious danger to others and his capacity for self care was seriously diminished, therefore he fulfilled the test for mental disorder under the act. The tribunal held that section 4 only excluded those who indulged in drug abuse. It did not exclude those, who as a result of drug abuse suffered from a mental disorder.

On the other hand, the case of *Re W [mental health]*[97] concerned a patient who had been using marijuana and LSD since the age of 16. Whilst he had had mental state fluctuations when using drugs, he had not had psychotic symptons in the past six months and it was found that his current residence in hospital was only to coerce him into treatment and maintain him in a hospital at a time when he was psychotic.

Judge MacCormick held that W was not mentally disordered under the MH(CAT) since there was no nexus between the abnormal state of mind and the serious danger or serious diminishment of capacity of the patient for self care at the time of the hearing. More importantly, the judge also went on to hold:[98]

> that the provisons of that Act and the treatment to be provided under it are only to be used for those considered to be currently mentally disordered in terms of the definition, rather than for those who are at the relevant time suffering from some other illness, disbility or addiction.

This is a reflection of the narrower interpretation of section 4(d) mentioned earlier. It would be fair to say that the judge was of the opinion that at the relevant time, the Act will

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[96] *In the Matter of B* [1994] NZFLR 966.
[97] *Re W [mental health]* 13 FRNZ 57.
[98] See above, 60.

not cover those suffering from "some other...addiction."[99] This would therefore exclude 'dual diagnosis' patients from the scope of the Act since at the time the patient was mentally disordered, he/she would be suffering from some other addiction. Judge MacCormick noted in obiter that a further application for detention and treatment could be made under section 9 of the ADAA.

The two differing interpretations reflect the backgrounds from which the judgement was made. *In the matter of B*[100] was decided by the Mental Health Tribunal while *Re W*[101] was decided in the District Court. Judge MacCormick's interpretation reflects the penal sentiment in treating alcoholics which only covers patients who are a serious danger to society or themselves. The Tribunal with its medical focus had a wider interpretation with a greater emphasis on treatment. This would mean a more preemptive cover under the legislation. Judge MacCormick also emphasised that at the time of the hearing, W had not experienced psychotic symptons in six months and thus was not mentally disordered. However it is well known that mental disorders often reoccur and W had a prior history of psychotic behaviour as well as having attempted suicide in the past. If Judge MacCormick's interpretation is preferred, it would not allow for preemptive detention and treatment of patients with the potential to cause harm to others or self harm.[102]

The author submits that for the MH(CAT) to have an effective and comprehensive coverage of patients with genuine mental disorders, the wider interpretation would be preferred. This is consistent with the intrepretation adopted by the Ministry of Health.[103] It would be unfair to exclude such patients simply because they were suffering from a drug abuse problem at the same time especially since cover under the ADAA may be inadequate.

B The Scenario in the Health Industry

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[99] As above.
[100] See n 97.
[101] See n 98.
[102] A classic case of "it ain't broke, don't fix it."
[103] Interview with Michael Webb, Solicitor/Analyst, Ministry of Health.

Judge MacCormick in *Re W*[104] states that a compulsory detention and treatment order could be made under section 9 of the ADAA. If such a detention order could realisstically be made, section 4(d) of the MH(CAT) may be interpreted narrowly and 'dual diagnosis' patients may still be covered.

As noted earlier,[105] a section 9 order may only be made if a certified institution under the ADAA is willing to receive the patient. It is unlikely that a certified institution would receive a 'dual diagnosis' patient. This is because these institutions often have a lack of resources or staff who are competent in dealing with mental health problems. Of all the Salvation Army Bridge programmes in New Zealand, only Christchurch deals with 'dual diagnosis' patients.[106] Furthermore, it is believed that mental patients do not have the proper mental attitude to attend a drug abuse programe.

In reverse, the Mason report also found that psychiatric facilities had denied admission to patients until they were drug free or sober.[107] This therefore results in the 'ping-pong' effect.

C Ping -Pong Effect

It is likely for a 'dual diagnosis' patient to experience the 'ping-pong' effect on obtaining treatment for their problems. This occurs when a patient entering treatment in either the mental health or drug abuse areas are diagnosed and treated only in that relevant area of expertise. This leaves the other disorder untreated. The patient on finishing treatment is still likely to warrant attention for their other disorder and since the two disorders are

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[104] See n 98.
[105] See above part II E.
[106] See n 33.
[107] See n 88.

inextricably linked, it is likely that the patient will revert back to suffering from both disorders. [108]

> Alcohol treatment services may find themselves unable to treat the psychiatric condition but may have difficulty when they try to refer such patients back to psychiatric services. The psychiatric service may consider that the condition does not warrant hospitalization, or that the symptons are sure to to alcohol abuse, which they do not regard as their responsibility.

This is because of the lack of cooperation and communication between the mental health and drug abuse services. The Mason report reccomends a multi-disciplinary approach with greater integration of assesment and treatment programmes between the two services.[109]

D Conclusion

This splitting between the Mental Health and Drug Abuse services in the Health industry has manifested itself in the legislative gaps evident between the ADAA and the MH(CAT). It is important that any discrepancies in the interpretation of s4(d) of the MH(CAT) and the scope of its restriction be decided by the Ministry of Health and that it take steps to direct practitioners, health service providers and members of the justice system as to its proper interpretation.

The author submits that in line with the treatment and care principles of the MH(CAT), the wider interpretation in *In the Matter of B*[110] be preferred. Furthermore the narrower reading of the section 4 restriction should be used until a realistic and workable equivalent is provided for in the ADAA.

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[108] See n 11, 100.
[109] See n 88, 72. This fact was recognized three years ago in guidelines issued by the Ministry of Health on treating Dual Diagnosis patients.See n90. Sadly, greater steps are needed to provide for these patients.
[110] See n 97.

These legislative steps are still ineffective unless the recommendations in the Mason report are firmly endorsed and acted upon by the Ministry of Health. There must be a greater integration of services between the Mental Health and Drug Abuse services. Staff in both areas must also be trained to diagnose and treat 'dual diagnosis' patients. Such treatment should take the form of a 'hybridisation' of treatment programmes and a case mangement basis for each patient.

VI ALTERNATIVE SENTENCING FOR ALCOHOL/DRUG OFFENDERS

It is firmly established in New Zealand that a large proportion of crimes committed are as a result of alcohol or drug use. Thus the harm caused by drug abuse not only harms the abuser but its behaviourial effects and social harm effect the community at large. "It is generally agreed that it (alcohol and drugs) is a significant aggravator of violence, contributing substantially to street violence and disorder, family violence, violent crime, and general anti-social behaviour."[111]

Therefore the question remains: "what do you do with offenders who are alcoholics?" Is there any purpose served by incacerating such persons? In many ways civil commitment is similar to imprisonment but the difference lies in the results the two will achieve. Imprisonment only serves to punish and deter a person from reoffending but what use is that when the reasons of the person's offending is causally connected to their drug abuse? Would not sentencing them to civil commitment in a drug abuse programme be of more use to society and the offender themselves? Alternative sentencing would serve two main purposes. First it would help rehabilitate the offender so as to integrate him/her back into society. Secondly, it would protect society from any potential harm by allowing the offender to remain at large. There is also a general perception that such alternative sentencing may be seen as a 'soft' option for such offenders. However if the crime is truly

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[111] Ministry of Health *Issues Paper Towards a National Drug and Alcohol Policy* (Wellington, 1995), 6.

addiction driven, such treament programmes will pose a challenge to such offenders. Besides being committed, they will also have to fight off the addictions which they crave. "There is a punitive element in it, because the strict regime of Odyssey House in particular is a considerable challenge; it is not unknown for offenders to prefer a sentence when given that option."[112]

The structures and facilities already exist in the New Zealand justice system for the alternative sentencing of alcohol and drug offenders. This chapter seeks to state the current situation and its deficiencies. The author submits that there is a need for a more transparent structure in the alternative sentencing for drug and alcohol offenders in New Zealand, and that this would be achieved by sentencing provisions in the Criminal Justice Act relating to compulsory detention and treatment under a new ADAA. It is important to note that such a legislative structure may still be inefficient in practice.[113]

> "[I]t is clear that what is possible under legislation is not always reflected in practice. Where legislation makes counselling available, inadequate funding to services may prevent it. Similarly, where no legislative provisions are available to divert offenders, the practices and informal agreements between police and others may encourage it."

For such legislation to be effective it must be ably supported by the Ministry of Health and the Department of Corrections of the Ministry of Justice.

A *An Omission in the Criminal Justice Act 1985 (CJA)*

It is interesting to note that in the current CJA, there is no sentencing provision which allows for a judge to make a detention order under the ADAA. There are however

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[112] *R* v *Ward* Unreported, 29 September 1989, Court of Appeal, CA 182/89, 6. [1989] BCL 1817.
[113] Alcohol and other Drugs Council of Australia *Alternatives to the Prosecution of Alcohol and Drug Offenders* (Sydney, 1994), 18.

equivalent provisions with regard to the MH(CAT).[114] This omission seems even stranger considering that s48A of the previous Criminal Justice Act[115] was such a provision. The provision was a subsequent amendment with the enactment of the ADAA in 1966. Section 48A provided that:[116]

> If, on the conviction before any Court of any person for any offence of which drunkeness or the taking of drugs forms a necessary element, or for any offence which is shown to have been committed under the influence of alcohol or drugs or of which drunkeness or the taking of drugs is shown to be a contributing cause, it appears to the Court or Judge that the offender is an alcoholic within the meaning of the Alcoholism and Drug Addiction Act 1966 or is a person to whom section 3 of that Act applies, the Court or Judge may, if it or he thinks fit, make an order requiring the offender to be detained for treatment for alcoholism or, as the case may be, for drug addiciton in an institution within the meaning of that Act.

It is also strange that section 102 of the CJA covers a situation where a person is subject to a sentence of imprisonment but is instead detained in a certified institution under the ADAA. The question therefore remains as to whether there is a current need for such a provision?

B Other Options Under the Criminal Justice Act 1985 (CJA)

Under the current CJA, there are a variety of sentencing options which may allow for compulsory detention under the ADAA. Community programmes[117] allows an offender to be placed in a community programme 'for a period not exceeding 12 months'. It is unlikely

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[114] Part VII of the Crimnal Justice Act 1985.
[115] Criminal Justice Act 1954.
[116] As above, s 48A.
[117] As n 114, s 53-57.

that this 12 month period would be sufficient to treat a hardened alcoholic and would not be suitable for the hardened addicts the ADAA purports to cover.[118] Furthermore, community care requires the consent of the offender, although this would be similar to a 'voluntary' application for detention under the ADAA.[119]

The other viable alternatives similar to civil commitment under the ADAA are corrective training[120], imprisonment[121] and preventive detention.[122] However both imprisonment and preventive detention do not allow for such civil commitments in their respective definitions. Corrective training is also unsuitable since it is restricted to persons aged between 16 to 20 years and is limited to only 3 months in duration.[123]

It is important to note that whilst such alternatives are unsuitable compared to the treatment and detention orders available under the ADAA, there may still be other treatment options which would be more suitable for the offender other than civil commitment. These may be outpatient treatment programmes or rehabilitation and counselling programmes. In those cases, community programmes, periodic detention or supervision may be used for such purposes. In the case of supervision, links between the probation officer and the service providers are essential for the success of the program.

Part VII of the CJA referring to the commital of mentally disordered or disabled persons under the MH(CAT) would also be unsuitable for alcoholics or drug users. This is because such an offender must satisfy the definition of 'mental disorder' under the MH(CAT).[124] It may however be suitable for sentencing 'dual diagnosis' patients.

C Common Law Approaches to Alternative Sentencing.

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[118] Whilst there is no standard length of time required to treat a alcoholic, the ADAA allows for a maximum stay of 24 months under section 10 of the ADAA.
[119] See n 6, s 8.
[120] See n 114, s 68-71.
[121] See n 114, s 72-74.
[122] See n 114, s 75-77.
[123] See n 114, s 68.
[124] See n 39, s 2. See above part V.

Although no legislative provison has existed to sentence drug and alcohol offenders to compulsory treament and rehabilitation centres in New Zealand, the courts have still managed to do so in a large number of cases.

In sentencing alcohol and drug offenders, the court must take into account various factors in deciding the appropriate sentence. These factors are a genuine desire to change and reform[125], the likelihood of the offender reforming[126] and whether there was a clear nexus between the offending and the offender's addiciton.[127] A common approach is to remand offenders on bail on the condition that they undergo treatment for their addiction at structurred and supervised programmes such as Odyssey House, the Salisbury Foundation or Moana House. Upon receiving a favourable report, the judge will often impose a sentence of supervision with provison for treatment. This therefore catches offenders lying to get a 'softer'[128] sentence.

The Courts have also used section 6(4) of the Misuse of Drugs Act[129] to allow for alternative sentencing of drug offenders. In the case of *R* v *Hoddinott*[130], the offender's attempt to rehabilitate constituted 'particular circumstances' thus allowing a judge to impose a non-custodial sentence.

D Conclusion

Case law has indicated that the courts are aware of the advantages of alternative sentencing and have provided for this with the existing measures in the legislature. Most of the

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[125] *R* v *Phillip* Unreported, 19 March 1982, Court of Appeal, 5 TCL 11/7.
[126] This is determined through favourable reports of the offenders response to treatment at an institution while remanded on bail.
[127] *Day* v *Police* Unreported, 23 August 1991, Rotorua High Court, AP55/91.
[128] See above part V.
[129] Misuse of Drugs Act 1979.
[130] *R* v *Hoddinott* (1992) 9CRNZ 262, 265. "The combination of the very real assistance given to the police in this case, coupled with what must be regarded as exceptionally sucessful efforts to rehabilitate

alternative sentences have not been as severe as civil commitment but the author submits that it is because its severity that the courts have been less likely to impose compulsory detention orders without express legislative provision. The lack of a transparent sentencing structure for compulsory treatment orders through the ADAA has deterred the use of civil commitment as a form of alternative sentencing. The fact that they have done so in the few cases notwithstanding that indicates that some offenders require inpatient treatment for their addicitons. The author submits that the current situation is inadequate for several reasons. The institutions that such offenders are referred to are not under any control or guidelines provided by the Ministry of Health. Insitutions which have been popular in such alternative programmes have been Odyssey House, the Salisbury Foundation and Moana House. However they are not certified insitutions under the ADAA for the treatment of alcohol and drug offenders. This is no reflection on the institutions rather it has been four years since the Ministry of Health last gazetted the list of certified institutions under the ADAA.[131] It is essential that for alternative sentencing to be effective, the Department of Corrections and the Ministry of Health must draw up a set of guidelines which will take into account the punitive and rehabilitative nature of such sentences. It is also essential that the Ministry of Health provide the courts with current information regarding the specific institutions suitable for such sentencing.[132]

> Where an offender expresses a desire for rehabilitation, the court should be provided with information from a recognised drug rehabilitation centre as to the programmes offered by the particular institution and, if appropriate, their sucess rates, an objective assesment of the offender's willingness to participate, and a prognosis of whether the treatment would be sucessful.

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themselves, constituted 'particular circumstances of the offenders' within the meaning of s6(4) and left the way open for the judge to deal with them by way of supervision."

[131] This indicates that this piece of legislation has been ignored even by the Ministry responsible for it.

[132] G G Hall *Hall on Sentencing* (Butterworths, Wellington, 1993), ch B, 180.

The author further submits that in the case of alcohol and drug offenders, there should be express legislative provisions similar to section 48A of the CJA 1954 or part VII of the CJA dealing with mentally disordered patients, to allow alcohol and drug offenders to be compulsorily detained and treated under the ADAA. This is necessary to provide a transparent sentencing structure for judges to commit alcohol and drug offenders for treatment to certified institutions.

VII "IF YOU DRINK THEN DRIVE, YOU'RE A BLOODY IDIOT."

Probably the greatest area of concern in New Zealand regarding alcoholism and drug addiction is drunk- driving.[133] The Alcohol and Liqour Advisory Council and the Ministry of Transport have all launched extensive ad campaigns to educate New Zealand drivers on the dangers of drunk-driving in New Zealand. "It [alcohol] is a contributing factor in fatal crashes and injury crashes (33% and 18% respectively in 1994)."[134] Therefore in reviewing the ADAA, there should be a focus on the area of drink driving. There are various ways in which the ADAA may help in this regard.

The author submits that in reviewing the ADAA, there should be a provision disqualifying all patients committed under the ADAA from driving.[135] It may be argued that if a person is being committed under the ADAA in an institution, then the person would not be allowed to drive anyway. However if community treatment orders were endorsed by the Ministry as another form of treatment under the ADAA, then such committed patients should be disqualified from driving and have their licenses removed. Their disqualified status shall continue until they have been discharged from treatment under the Act.

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[133] Please note that in the context of this paper, drunk-driving refers to driving under the influence of either drugs or alcohol.

[134] See Ministry Of Health *Issues Paper Towards a National Drug and Alcohol Policy.* (Wellington, 1995). "Drink-driving offences totalled 32,634 in the year to June 30, compared with 30,078 last year. Injuries involving alcohol grew from 3089 in 1994 to 3234 last year." *The Evening Post*, Wellington, New Zealand, 23 September 1996, 5.

Harry Duynhoven, transport spokesman for the Labour party, recently stated that if the Labour party became the government, it would disqualify drink drivers for five years if they were convicted for drunk driving three times in the space of three years.[136] Furthermore, if they offended during their five-year ban, they would lose their licenses permanently.

It may be argued that after a patient has been discharged from committal or a treatment order under the ADAA, they should still be disqualified from driving for a set period. However the problem with recidivist drunk drivers is that they are often caught because they have been driving while disqualified. The loss of their license therefore does little in preventing them from driving again. In dealing with recidivist drunk drivers, the government's focus should be on the treatment of such drivers if there offending is a result of their addictions.

A Recidivist Drunk Driving

The greatest problem in the area of drunk driving are recidivist drunk drivers. These drivers pose a high risk to society as they are three times more likely to be involved in a reported injury/fatal crash than the 'average' driver.[137] Section 30A of the Transport Act[138] is similar to the ADAA as it seeks to treat and rehabilitate alcoholics. However its specific focus is on recidivist drunk drivers. The section was implemented as a proactive intervention which had the potential to break a cycle of serious, habitual traffic offending and alcohol abuse.

Under section 30A, drivers may be convicted under the provision if they satisfy its criteria:

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[135] In this regard it would be similar to declaring a person medically unfit under section 45A of the Transpot (Vehicle and Driver Registration and Licence) Act, 1986.
[136] See n 134.
[137] *Issues paper on Recidivist Drunk Driving* (Draft, Ministry of Health, Wellington, 1996).
[138] Transport Act 1962.

1) they have been convicted of two or more drink-driving conviction within 5 years, and;
2) at least one of the offences, the driver has had a very high blood or breath alcohol level or been convicted of a disobedience offence.[139]

The imposition of such a sentence is mandatory if the criteria are satisfied.[140] The person is then disqualified from holding a driver's license and is ordered by the court to attend an approved drug and alcohol assesment centre.

Whilst the drivers are disqualified for an indefinite period, after two years the offender applies to the Director of Land Transport to reinstate the license if the director is satisfied that the offender is fit to hold a license.[141]

B Problems with the Section 30A Transport Act

Over the years, section 30A has proved inefficient and unsatisfactory in its efforts to remove recidivist drunk drivers from the road. There are several problems with the section. Disqualifying these drunk drivers serves no real purpose as in many cases they continue to drive anyway. In some cases, some of these drinkers do not even have driving licences in the first place. And because there is no terminating provision, nothing happens if the person chooses not to undergo treatment. In reality most of the offenders receive their licenses after two years even if they have not received any treatment or assesment.

The legislation is "failing to achieve its purpose because there is no incentive for offenders to attend the first assesment before the expiry of the two year disqualification."[142]

Finally the criteria which seeks to define the target group of alcoholic recidivist drunk drivers fails because either they are not alcoholics, being binge drinkers, or they consistently offend but never attain the high breath-alcohol readings or comply with testing.

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[139] A disobedience offence is one where the driver refuses to accompany the officer or fails to remain at a place for either the purposes of a breath or blood alcohol tests. See n5, section 30A.
[140] See n 137, s 30A(1).
[141] See n 137, s 40.
[142] See n 136, 5.

It seems strange that persons guilty of disobedience offences may be covered under the section since refusing to be tested does not indicate that you are an alcoholic.

The major problem behind the failure to revise the section earlier has been because it is a multi-sectoral concern. A number of ministries such as Transport, Justice and Health need input into any such review since the section's effectiveness is dependant on the provision of funding and resources from the ministries.

C Possible Reforms to the Section

The author believes there are several ways in which section 30A may be improved. The most important reform would be that if the ADAA were to be reviewed, special provisions should include referrals from drink-drivers convicted under section 30A. Therefore recidivist drunk drivers could be committed for treatment in an institution. The definition under section 30A however must be reworked to include alcoholics and not binge drinkers. The ADAA is suitable because such referrals would increase the usage of the ADAA. Furthermore the ADAA provides a commital process and treatment procedures under certified institutions controlled by the Ministry of Health. This would then be similar to the situation of alternative sentencing which seeks to treat the offender for their addictions.

It may also be argued that special provisions are not necessary since under section 2 or 3 of the ADAA, it is possible to admit a drunk-driver since they would be "likely to cause serious injury to his health or is a source of harm, suffering, or serious annoyance to other or renders him incapable of properly managing himself or his affairs."[143] The author submits that it is still essential that there be provisions in the Transport Act which serve to direct judges that recidivist drunk drivers should be dealt with under the umbrella of the ADAA.

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[143] See n 6, s 2. Also see part II B & C.

Another reason why the ADAA should be used is because it would compell such drink drivers to receive treatment.[144]

> "[The] Ministry of Health believes that most offenders continue to avoid assesment and any necessary rehabilitation. One option favoured for better offender compliance is for some degree of compulsion to be able to be ordered by the court."

The ADAA would allow the courts to order the a drunk driver be detained in a certified institution for treatment under section 9. It would also solve the problem of recidivist drunk drivers who drove while disqualified anyway. However the courts should consider committal orders only for drivers who drove while disqualified. This is another reason for the provision of community treatment orders as it would be consistent with the 'least restrictive alternative' principle.

Therefore by using the ADAA as the main structure for the treatment of such recidivist drunk drivers, they would be compelled to attend such treatment procedures. Also by having a review process of a person's response to the treatment programme, this would provide an incentive for the driver's to respond to the treatment procedures. Therefore the term of disqualification would be dependent on how receptive the driver was to treatment.

Another alternative would be for the judiciary to use the ADAA as an assesment process before deciding what sentencing measuresa were suitable. This would use the two medical certificates required under a section 9 committal to decide if a person was truly an alcoholic. The Police commented that: "[t]o be of any value, s30A should require an assesment to be carried out within a short time of conviction and, where an alcohol related problem is identified treatment should be mandatory."[145]

Therefore by linking the ADAA with s 30A, it would serve to treat recidivst drink drivers for their addictions.

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[144] See n 136, 5.

VIII AN INDEPENDENT ACT OR A SEPARATE PROVISION IN THE MH(CAT)?

A final question remains in this review of the ADAA. If there is to be new legislation concering the treatment of alcoholics and drug addicts, should this be incorporated into the MH(CAT) as a separate provision or should it exist as a piece of independent legislation?

In considering the then new MH(CAT) in 1991, consideration was given to providing a separate section of the Act towards dealing with drug addiction. However this was deemed unnecessary because there was still the separate legislation in the ADAA and it was thought that by treating alcoholics and drug addicts under the Mental Health legislation, this would create a stigma by labelling drug addicts as 'mental patients'.[146] It was seen that such negative labelling might discourage relatives from seeking treatment under the Act for their loved ones.

The author believes that there are valid arguments for and against such a provision in the MH(CAT). The MH(CAT) already has in place many of the structures that would improve the ADAA such as complaints processes, adequate protection of patient's rights and community treatment orders. Furthermore it would also serve to provide an amalgamated legislative response towards the problem of dual diagnosis patients.

In the end, the package of a new ADAA would be unlikely to have a great impact on the dynamics of the new legislation so long as its contents were effective and ably supported by resources.

IX CONCLUSION

This paper has sought to do two things. First, to state the inadequacies surrounding the Alcohol and Drug Addiction Act and secondly, to provide possible reforms and focus areas

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[145] See n 136, 6.

for a review of the legislation. The ADAA is a draconian and antiquated piece of legislation that has remained largely unchanged since its form as the Reformatory Institutions Act in 1907. Numerous issues such as the definitions contained in the Act and the commital procedures must be clarified to make the Act easier to use.

The author submits that the problems of alcohol and drug addicition in New Zealand warrant an effective policy by the Ministry of Health. This may be achieved through a review of the ADAA legislation and the provision of adequate resources and services to match it. The author further submits that the ADAA has the potential to be an effective tool in helping treat the most hard core drug addicts as well as less extreme cases. By increasing its cover in fields such as alternative sentencing, recidivist drunk drivers and dual diagnosis patients, the ADAA will be seen as the backbone of the Ministry's policy to help such addicts. It would serve as a conduit for addicts committed though civil applications and those referred from the Criminal Justice system. This increased coverage would also hopefully see joint funding provided by the different Ministries involved.

While it may be argued that for alternative sentencing and recidivst drunk drivers, the current ADAA would suffice to provide commital procedures. However, apart from the inherent problems with interpretation and the procedural processes mentioned earlier, the courts have been reluctant to use the ADAA for such purposes. The author believes there are several reasons for this. This may be because few judges know about it or that the judiciary believe compulsory detention to be too extreme a measure in some cases or that the Act is not ably supported by adequate services. The author believes that the reviews proposed in this paper should address most of these concerns.

The provision of community treatment orders would also reflect the trend towards a more out-patient focus in treatment methods. More treatment options would also make that ADAA more acessible for people looking for less extreme methods of treating their relatives or friends. The author submits that there is still a need to provide for compulsory treatment

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[146] See n 103.

orders in institutions for the hardcore addict who refuses to admit his or her problem and alcohol or drug offenders who require a rehabiltative element to their punishements. In making such orders, the powers must be exercised in line with the principles of the 'least restrictive alternative' and the protection of the patient's rights.

The Act however is only as effective as the resources and services that support it. Currently addicts seeking to be admitted into an inpatient treatment programme in their regional health area may face a waiting time of between six to twelve weeks. This is dependent on their suitability and the availability of such spaces.[147]

The author's recommendations of community treatment orders, assesment procedures and the provision of patient complaints process would require an increase in resources and services. The Mason report was especially concerned with the lack of resources available to support the Mental Health regime. "What can be said for certain is that all services including crisis support, assesment, treatment and continuing support are fargmented and under resourced, both in skill and size. Co-ordination, in many services is non-existent."[148] It is likely that if a new ADAA were to be implemented, a similar situation would arise. From an academic standpoint, the author hopes that the review of the ADAA and the reforms suggested would be considered as viable optioins by the Ministry of Health.

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[147] Interview with Colin Lee, Counsellor, Wellington Alcohol and Drug Services.
[148] See n 88, 100

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ORDER FOR DETENTION UPON VOLUNTARY APPLICATION

Section 8, Alcoholism and Drug Addiction Act 1966

Whereas _____ _____
(Name) (Occupation)

of _____

has made application under Section 8 of the Alcoholism and Drug Addiction Act 1966 for an order under that section;

and has specified the institution situated at _____

and known as _____ as the institution into which he desires to be received.

And whereas the said _____
(Name of Applicant)

has appeared before me and I am satisfied that the said _____

_____ is an alcoholic *(or drug addict) and that he fully understands the nature and effect of his application and that the managers *(or superintendent) of that institution are *(is)

willing to receive the said _____
(Name of Applicant)

into that institution.

Now therefore, I do order that the said _____
(Name of Applicant)

be detained for treatment for alcoholism *(or addiction to drugs), in the institution situated at

_____ and known as _____

Given under my hand at _____ this _____ day of _____ 19 ____

_____
(Magistrate)

* Strike out words which do not apply

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Application of Relative or Other Reputable Person for Committal Order

Section 9, Alcoholism and Drug Addiction Act 1966

To a District Court Judge at _____

I, _____, _____
(Name) (Occupation)

_____
(Address)

hereby make application pursuant to Section 9 of the Alcoholism and Drug Addiction Act 1966 in respect of

_____, _____
(Name) (Occupation)

_____
(Address)

hereinafter in this application referred to as the said person; on the grounds that the said person is an alcoholic *(or drug addict).

believe that the said person is an alcoholic *(or drug addict) because (set out full reasons for applicant's belief).

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

am _____, _____ to the said person (to be
(Insert degree of relationship, if any or words "not related")

mpleted only if the applicant is not a relative† of the said person): this application is made by me instead of by

relative because (state reason): _____

_____

Dated at _____ this _____ day of _____ 19___.

_____
(Signature of Applicant)

*Strike out words which do not apply.

†Relative for the purposes of Section 9 of the Act means spouse, parent, grandparent, stepfather, stepmother, brother, sister, half brother, half sister, son, daughter, grandson, granddaughter, stepson or stepdaughter.

STATUTORY DECLARATION

(To be completed unless District Court Judge otherwise permits)

I, _____ , _____
(Name) (Occupation)

of _____
(Address)

solemnly and sincerely declare that the statements contained in the foregoing application under Section 9 of the Alcoholism and Drug Addiction Act 1966 are true; (add "to the best of my knowledge and belief" if declaration is made by person other than applicant).

And I make this solemn declaration conscientiously believing the same to be true and by virtue of the Oaths and Declarations Act 1957.

Declared at _____
this _____ day of _____ } (Signature)
19 ___.

Before me _____
Justice of the Peace, solicitor, or other person authorised to take a statutory declaration.

58838E—3000/8/86PTK

SUMMONS

Section 9, Alcoholism and Drug Addiction Act 1966

To .....(NAME)....., ...(OCCUPATION)

of .....(ADDRESS).....

.....(NAME)..... .....(OCCUPATION)

of .....(ADDRESS).....

has stated that you the said .....(NAME).....

are an alcoholic and, or drug addict.

You are summoned to appear on the ..... day of ..... 19.....

at ..... a.m. (p.m.) before a District Court Judge at the District Court at .....
to show cause why an order should not be made requiring you to be detained for treatment for alcoholism (and or) drug addiction in an institution.

Dated at..... this ..... day of ..... 19.....

.....
DISTRICT COURT JUDGE
AT THE DISTRICT COURT

Note - Section 35 (1) of the Alcoholism and Drug Addiction Act 1966 provides that every application under that Act shall be heard and determined in private.

** Delete whichever inapplicable*

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99850C-1,000/9/89 M

WARRANT TO ARREST

Section 9, Alcoholism and Drug Addiction Act 1966

To Every Constable:

In an application dated the ..... day of ..... 19 ..... and made under Section 9 of the Alcoholism and Drug Addiction Act 1966 it has been stated that .....

..... (NAME IN FULL) (OCCUPATION)

of ..... (ADDRESS)

is an alcoholic *(and/or) drug addict.

I am satisfied, by evidence on oath, that a warrant is necessary to compel the attendance of the said

..... (NAME IN FULL)

to show cause why an order should not be made requiring him to be detained for treatment for alcoholism *(and/or) drug addiction in an institution; or I am satisfied, by evidence on oath, that circumstances exist that render the issue of a warrant expedient;

†And I am further satisfied that the said ..... (NAME IN FULL)

has refused to undergo examination by two medical practitioners for the purposes of the Alcoholism and Drug Addiction Act 1966 or the said .....

has wilfully failed to attend for medical examination required for the purposes of the said Act:

AND I DIRECT YOU to arrest the said .....
and bring him before a District Court Judge as soon as possible, to be dealt with in accordance with the Alcoholism and Drug Addiction Act 1966;

†AND I FURTHER DIRECT that the said .....

shall, after his arrest, undergo medical examination by .....,

and ..... being two medical practitioners.

Dated at ..... this ..... day of ..... 19 .....

..... (DISTRICT COURT JUDGE)

*Delete whichever is inapplicable
†Delete if inapplicable

99844H–1,000/9/89MK

Section 9, Alcoholism and Drug Addiction Act 1966

..... of .....

....., being a medical practitioner

egistered in New Zealand, do hereby certify that I believe .....

....., ...
(Name) (Occupation)

f .....

an alcoholic within the meaning of the Alcoholism and Drug Addiction Act 1966 *(or a drug addict within the meaning of the lcoholism and Drug Addiction (Forms) Regulations 1968) and that the making of an order for his detention and treatment as such expedient in his own interest *(or in the interest of his relatives).

he following are the reasons for my said belief (Set out reasons in full).

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

hereby declare that I am not prohibited by Section 32 of the Alcoholism and Drug Addiction Act 1966 from signing this certificate.

Dated at ..... this ..... day of ..... 19.....

.....
(Signature of medical practitioner)

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**Strike out words which do not apply.*

N.B. Reverse

Committal Order on Application by Relative or Other Reputable Person

Section 9 (7), Alcoholism and Drug Addiction Act 1966

Whereas ..... (NAME), ... (OCCUPATION)

of .....

(being a relative of ..... (NAME OF PERSON TO WHOM APPLICATION RELATES))†

has made an application dated the ..... day of ..... 19..... pursuant to section 9 of the Alcoholism and Drug Addiction Act 1966 in respect of

..... (NAME), ... (OCCUPATION)

..... (ADDRESS)

on the grounds that the said .....
is an alcoholic *(or drug addict):

And whereas ..... (NAME AND ADDRESS OF MEDICAL PRACTITIONER)

.....

and ..... (NAME AND ADDRESS OF MEDICAL PRACTITIONER)

.....
have given evidence *(or certificates in the prescribed form) to the effect that they believe the said

..... to be an alcoholic *(or drug addict) and that his detention and treatment as such is expedient in his own interest *(or in the interest of his relatives):

And whereas the said .....

has appeared before me and I am satisfied that the said .....

..... is an alcoholic *(or drug addict) and that the managers *(or superintendent) of the institution situated at ..... and known as

..... (NAME OF INSTITUTION) are *(is) willing to receive the said ..... into that institution:

Now, therefore, I do order that the said .....
be detained for treatment for alcoholism *(or addiction to drugs) in the institution situated at

..... and known as .....

Given under my hand at ..... this ..... day of ..... 19.....

*Strike out words which do not apply.
†Delete if inapplicable.

.....
DISTRICT COURT JUDGE.

30740C—1,500/2/85MK

Tan, Marc Wei-loon
A review of the Alcoholism and Drug Addiction Act 1966